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ABSTRACT

This paper reviews issues in the provision of services to individuals who are mentally ill chemical abusers and addicted (MICAA). Introductory material defines this population and notes that these people are frequently ineligible for services aimed at either mental illness or chemical abuse alone. Service provisions within the psychiatric/mental health care system are briefly described. Topics discussed include: implementing alcohol/substance abuse programs in the psychiatric care system for MICAA's; content of treatment; special problems when mental health staff are not substance abuse experts; the training of mental health professionals in substance abuse concepts; working with families, friends, and advocates of MICAA patients; services not provided by mental health agencies (e.g., drug and alcohol detoxification and rehabilitation); and continuity of care. Specifically mentioned are programs under the leadership of the New York State Office of Mental Health, including five training sites. (Contains 19 references.) (DB)

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MENTAL ILLNESS, ALCOHOLISM, SUBSTANCE ABUSE, MULTIPLE DISABILITIES..... WHOSE PATIENT, WHOSE TREATMENT APPROACH?

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MENTAL ILLNESS, ALCOHOLISM, SUBSTANCE ABUSE, MULTIPLE DISABILITIES... WHOSE PATIENT, WHOSE TREATMENT APPROACH?

Kathleen Sciacca, M.A.

Mental illness, alcoholism, drug abuse and dependence, are not seen as discreet illnesses in many cases. Yet, our services are divided through their funding sources, treatment methodology and philosophies, and staff training. How does this effect the quality of care we are presently able to provide for the multiply afflicted? What new directions must be taken to improve upon our present system? Time Magazine (Gorman, 1987) stated that the federal Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) disclosed that at least 50% of the 1.5 million to 2 million Americans with chronic mental illness abuse illicit drugs or alcohol, compared with about 15% in the general population. This is an indication that a major portion of the patient population in the mental health care system have alcohol and/or drug problems.

In 1975 I volunteered my services to a therapeutic drug treatment community (TC) as part of my undergraduate internship in psychology. I was asked to provide my group therapy services to a group of patients/residents who were causing the director to express concern at some sense of loss as to what to do with this group. I began meeting with a group of approximately 10 residents, some of whom were being medicated, and were visibly sedated, all of whom had symptoms of mental illness that went beyond the

compatibility of the Therapeutic Community's treatment approach. It didn't occur to me at the time, that I was working with a group of what I later learned to be "dual diagnosis" patients: patients with mental illness more severe than could be contained under the drug dependence diagnosis, or within the system of care for drug treatment.

In 1977 I started working with persons who were primarily substance abusers: persons with a primary assessment of drug dependence, heroin, and other multiple abuse. Many of those people were also alcoholics, and many of them had mental health problems that extended beyond the expertise of most drug treatment staff, and beyond the drug dependence assessment to include personality disorders (Carroll, 1988).

In 1984 I began working at a psychiatric facility, in a day treatment setting where severely and persistently mentally ill patients were assigned for treatment. It was immediately apparent that many of those patients had alcohol and drug problems that were beyond the realm of what the treatment staff knew what to do about, but even more pronounced was the belief of the staff that they were not responsible to do anything, or in many cases, even to accept these patients since they held that they did not treat substance abuse disorders. Since then, I have specifically focused my work around this dually and multiply afflicted patient population.

There have been major strides in the changes that have taken place in the New York State Psychiatric care system, as well as in other states, and new directions are planned. Some drug treatment programs are beginning to address the problem of the multiply

afflicted (Carroll, 1988). Many alcoholism treatment agencies are in recognition of the mental illnesses their patients have, and send their staff to my seminars and courses and other courses as well, to learn about the Mentally Ill Chemical Abuser and Addicted (MICAA). In fact, a new acronym is becoming part of our vocabulary, Chemical Abusing Mentally Ill (CAMI). MICAA makes reference to severely mentally ill persons with substance abuse problems (New York State Commission on Quality of Care for the Mentally Disabled, 1986), that is patients with Axis I major disorders according to Diagnostic and Statistical Manual of Mental Disorders III-R (1987). CAMI refers to chemical abuse as the primary disorder, (usually chronic) with mental illness as concomitant and less severe, i.e., Axis II mental health disorders. CAMI may also refer to persons with chemical abuse as primary and acute toxic psychosis (usually short lasting) versus the functional psychosis found in the major mental disorders. For these patients the mental disorder does not persist discreetly but is precipitated by substance abuse, and abated by abstinence.

While working in the mental health system I observed that it was acceptable to reject a patient on the basis of the secondary disorder, i.e., the disorder that is not treated as primary in a given agency, be it alcoholism, drug dependence or mental illness. For example, a mental health professional could say, this person is an alcoholic therefore she/he belongs in an alcohol treatment program, let's not admit to treatment here, let's refer. The alcohol program could say, this person is schizophrenic, we can't treat that here, let's refer to mental health services. The

patient is one who "falls between the cracks" of our service delivery system. The cracks extend to housing, vocational opportunities, socialization and, eventually in some cases leads to homelessness. Some professionals in our system have attempted to narrow the cracks. They do this by a process of omitting information. For example, if a mental health professional is looking for a residence for a patient, they may have to omit the fact that the patient has an alcohol/ substance abuse problem, or if a residence seeks to obtain treatment for a resident, they will have to omit the fact that the person is an alcohol/substance abuser, and so on. Our MICAA patients have learned for a variety of reasons to hide these problems, and when the service delivery agencies prefer not to know, the agency will assist the process by overlooking the signs and symptoms. In a system such as this, a multiply afflicted person is confronted by rules that address his or her symptoms, but not with treatment. For example, a patient who got into a residence by omission of information, may well be evicted from that residence for drinking or drug use based upon the rules that are followed to keep the substance abusing populations out.

Where can the MICAA patient get help, be accepted, and have his/her real illness and problems attended to in a comprehensive system of care? The mental health agencies appear to be more willing to treat them since they have discovered it is possible to do so within their existing service agencies. Residences are developing that are specifically and exclusively for MICAA patients. Other residences are permitting some MICAA patients to

be integrated among other residents within their housing facilities. Some social club programs have recognized the needs of MICAA patients and are integrating them, or starting new programs specifically for them. Each time a new program or agency undertakes the MICAA population, the questions become ... What model of service must be used? What has to be different than what is usually done? How much can be borrowed from traditional alcohol/drug treatment approaches? What has to change?

Within the answers lie the differences of opinion across the different disciplines, i.e., alcohol, drug, and mental health treatment, differences that may result in healthy controversy, and yield optimal solutions; or differences that may keep us from coming together for the good of each of the sub-populations of MICAA and CAMI patients. Some of the answers and solutions to the MICAA patient in the psychiatric/mental health care system that have developed are as follows:

Implementing Alcohol/Substance Abuse Programs In The Psychiatric Care System For MICAA's:

To begin to treat mental illness and chemical use abuse in the psychiatric care setting, it is essential that the administrators of the agencies state their clear support of the implementation of such programs to everyone concerned. Mental health professionals who have a strong interest in learning about drug abuse and alcoholism are the most appropriate staff members to embark upon this work. They must have experience in treating major psychiatric disorders, i.e., schizophrenia, bi-polar disorders, etc., and they must be able to find gratification in treating the more difficult

to engage persons in our treatment systems. In the mental health care system in many cases we begin with the patient who has by necessity had to hide his/her substance abuse, who has encountered many losses because of the symptomatology related to her/his substance abuse, and who, understandably, is distrustful of the mental health professional when it comes to discussing these problems (Sciacca, 1987a).

With the severely and persistently mentally ill person the therapeutic process needs to be one of engaging the person to relate to the area of substance abuse in whatever way is possible. Traditional readiness for substance abuse treatment frequently cannot be met. In many agencies that treat alcoholism and drug dependence, treatment readiness means a person who is cognizant of the fact that alcohol or drugs is creating problems for them, and who is willing and ready to work on the problems. Working on the problems often encompasses an abstinence model, thereby agreeing to contract to be abstinent from the substance(s), and facing various consequences if they are not. The severely and persistently mentally ill person is not coming into the mental health treatment setting specifically for substance abuse problems, although in many cases the interaction between the multiple disorders creates a situation where the person is experiencing mental health symptoms that are precipitated by the use of substances. I have been fortunate to have the opportunity to develop interventions that assist the patient to attain the traditional readiness state (Sciacca, 1987b). Those interventions are in keeping with the basis of engaging the person in the

treatment process and keeping them engaged. Through my experiences in developing a treatment approach that does so, I have found it necessary that a person be permitted to engage in the process in the denial state, thereby denying that the use of alcohol and/or drugs is problematic, and unwilling to contract for abstinence; and not wanting treatment or help in abstaining. Therefore, there cannot be consequences for the person who does not abstain, except for those developed to maintain a safe environment for all concerned. Unsafe and/or potentially disruptive conditions include intoxication (which I advocate be seen by mental health professionals as a crisis state necessitating detoxification rather than psychiatric hospitalization when possible); selling drugs, which is an illegal offense that cannot be tolerated in any facility; or aggressive, violent or agitating behaviors that are inciting or dangerous to others and therefore cannot be tolerated in any treatment setting or approach including the substance abuse component of the patient's treatment.

The initial objective for the MICAA patient is to get him or her to engage in a process of education and discussion about alcohol and drugs. Through a pre-group interview which sets the tone for support, education, outside speakers, and open mindedness, the person gets the point that he/she does not have to discuss his/her own use to participate, or even to admit they have a problem. Engaging in the process of integral learning in the discussion groups helps the person to relate their own issues to the material in a non-confrontational, non-threatening manner. Participants interact around information from video tapes,

literature and guest leaders and speakers and discuss what they know or think they know about these materials. People are permitted to deny that they drink or use drugs even though it may be known by the staff that they do so. Urinalysis are not being done so that the person is not being tested in a way other than their own honesty. The process is gradual and takes a different amount of time for different people, but inevitably it has happened across numerous groups, in various programs and agencies, that the person will eventually begin to discuss his/her own use. The goal then becomes to help that person understand that use, and how it effects his/her well being, mental illness, the attainment of goals and any other impinging factors. Therefore, the ultimate goal continues to be getting at the truth concerning the person's use, abuse, and relapse. The consequences of relapse are not indicated as failure, hopelessness or poor prognosis to the patient, rather the patient is taught about relapse, about the illness/disease factors in substance abuse and how maintaining a state of remission requires on-going support and treatment, as does maintaining a state of remission with their psychiatric disorder. Here we find another difference with some of the traditional treatment settings for alcoholism and drug abuse. In traditional settings continual relapse can be considered an indicator that the person is not treatment ready or treatment compatible to the abstinence model of treatment. Consequences may be that after a fixed number of relapses the person faces termination from treatment. With the severely mentally ill person treatment continues, support continues and learning continues. Because we are beginning at a point where

the person is in denial and not seeking help (in many, but not all cases), we must gage our progress with these clients from that point on. We may have begun working with a patient who is loosely attached to treatment to begin with, who has never interrupted the cycle of exacerbated symptoms long enough to gain any insight about the interaction effects between their substance abuse and psychiatric disorders; in many cases, a person who has never discussed his/her use of substances in a treatment setting. These accomplishments with clients are seen as progress. Many of them progress to the stage of abstinence, some to long term abstinence, others maintain themselves at a level that is less traumatic and disruptive to their well being, but do not reach long term sustained abstinence with each of the multiple substances they abuse (this outcome is in the minority). For example, a patient who has hallucinations with the use of marijuana, will actively work on abstinence and may eventually abstain from marijuana, but will not see their alcohol abuse as a problem because it does not result in active symptoms. These patients are taught about the negative effects of various substances, and how these effects act as stressors upon their overall well being and progress. In all cases we accept the person's level of accomplishment and provide positive reinforcement for their progress at the level they have achieved. This may mean that a person who is working at abstinence but unable to accomplish it is praised for their motivation, their attendance, their ability to make supportive statements to others, their ability to form relationships, or any other positive factor about them, including their ability to be candid and honest about

their use, relapses, and despair.

Content of Treatment:

Psycho-education is an essential part of the learning process for MICAA patients. This includes areas that are specific to their needs such as the risk factors in mixing psychotropic medications with alcohol and illicit drugs; and the interaction effects between substance use/abuse and their psychiatric symptoms. As a by-product of this area patients learn a great deal about their mental illness as well. Education also includes areas that are relative to alcoholism, drug dependency, including the research that has been done about these disorders; the biological and neurochemical factors; issues regarding tolerance; detoxification; psychological dependence; and physical dangers; are among some topic areas.

Many severely mentally ill persons resist attending the traditional self-help groups such as A.A. or N.A. in the community, so it is recommended that A.A. or N.A. speakers be invited to the MICAA groups to speak to the members by telling their story and answering questions about self-help and recovery. Some patients may bridge the gap and begin to attend these groups. Their adjustment to these outside groups becomes the work and responsibility of the MICAA group leader. Patients sometimes find these self-help groups too structured, too intense, too demanding or too uncomfortable. Leaders help clients to use them in a way that works, or sometimes not use them at all.

Although self-help literature such as Alcoholics Anonymous (1984) states that it's all right for its members to take prescribed medications this is still sometimes taboo to some

individual self-help members. It is important that special groups are identified that may be more tolerant and welcoming of the severely mentally ill person. MICAA patients will sometimes tell other MICAA patients that they do not tell A.A./N.A. members that they take medication, therefore participating with omissions as they are so accustomed to doing. MICAA patients who attend self-help groups regularly have stated that in the A.A./N.A. meetings the non-MICAA members know who the MICAA's are and that they tend to stay away from them or ignore them, making those patients feel more isolated and different than they already do. Some MICAA patients adjust very well to A.A., and utilize the program in a constructive helpful manner. They also continue with MICAA and mental health treatment. Throughout the entire treatment process, patients remain engaged in the mental health treatment process. If in day treatment they continue as usual and attend the MICAA group in lieu of another activity. As clinic patients they continue to see a medicating physician, a primary therapist, and the MICAA group is a component of their treatment.

Staff Are Not Substance Abuse Experts:

In educating staff to provide this programming, it is necessary to build upon their skills and the understanding they have about mental illness, while simultaneously teaching them about the inherent factors relative to alcoholism/substance abuse. Many mental health professionals are unaware of the scope of the problems they are dealing with. The initial learning that must take place is related to alcoholism and drug dependencies as illnesses; the symptomatology and recovery process of those

illnesses. When viewing these factors realistically staff can understand the parallels between mental illness and alcoholism and substance abuse as illnesses. This results in staff's ability to tolerate the factors inherent in these problems, thereby changing their expectations of the recovery process, feeling less burned out and better able to assess the patients' progress and the fruits of their work. This is a distinct difference from the moral model perspective, i.e., that patients can stop the use of these substances at will, and if they don't their problems are their own fault, and they are deemed unfit for treatment, or at least considered not to be treatment ready. Counseling patients to stop using alcohol or drugs without a broad understanding of these addictions may be a wasteful pursuit;one that depletes the energy of staff and makes them feel inadequate. It is important for them to gain the degree of appropriate empathy for the substance abuse aspect of the patient's illness, as they have done for the mental illness.

Working With Mental Health Professionals:

Staff are taught what the disease model of alcoholism is about, and they are provided with some of the research that supports this concept (Ohlms, 1983). The disease model parallels the mental illness model in a way that is workable and understandable. For example: Many mental health professionals can readily understand the parallel twin studies that have been done for schizophrenia (Torrey, 1983) and for alcoholism (Goodwin, 1985). These studies show that individuals in sets of identical twins are more concordant for schizophrenia and alcoholism than are

individuals in pairs of non-identical twins, suggesting a genetic link. This is an important comparison since it removes moralistic perceptions of these behaviors and places the patient in a genetically predisposed or high risk category without individual blame for their physiological differences. In addition, staff are taught that both illnesses have active symptoms; active symptoms of both illnesses can be brought into remission; once active symptoms are in remission, neither disease goes away, it continues to be necessary for patients to have continued support and to be attentive to other stress constellations in their lives, and to learn about the precipitants to the onset of relapse; and in both illnesses there is a relapse factor that must be worked with and understood.

Staff learn about research which shows that in each of the disorders there are physiological factors that impinge upon the person and take part in the active stage of the illnesses (American Psychiatric Association, 1987; Wallace, 1985); the process of bringing the illnesses into remission (Bouricius, 1987; Jaffe & Ciraulo, 1985); and the process of keeping symptoms in remission. For example: In most cases of severe and persistent mental illness, those symptoms are medicated in an attempt to balance neurochemical factors in the brain (Bouricius, 1987). In alcoholism, symptoms may be caused by the alcohol itself either through the process of on-going brain tissue deterioration (Levin, 1987), intoxication resulting in acute organic symptoms (American Psychiatric Association, 1987), and by addictions resulting in tolerance to the substance (Levin, 1987).

In drug dependence, various drugs effect brain physiology in different ways, but all drugs effect brain chemistry. A specific example parallel to mental illness is cocaine abuse. Cocaine has been shown to cause large amounts of dopamine to emit from neurotransmitters (Wallace, 1985), a toxic state in cocaine/crack abuse may be evidenced by acute psychosis. The psychosis may represent similar if not identical symptoms to psychosis in schizophrenics or other major mental disorders. With cocaine another process happens, that of the destruction of dopamine rather than its preservation by the re-uptake, thereby creating a depleted state which results in depression. The cocaine abuser in the dopamine depleted state seeks more cocaine to relieve the depression (Levin, 1987). At the same time tolerance levels may be building and the person now needs more of the drug to reach the same effect, or in some cases simply to feel normal (Levin, 1987).

Mental health professionals who perceive a substance abuser as dealing with pure will power are not educated about the physiological processes that partake in the impulsivity and the needs that patients have to use substances.

In each case physiological processes are participating in active organic symptoms, and these symptoms need to be brought into remission. In mental illness, medication may be necessary to balance an imbalance. In alcoholism and drug dependance, detoxification, abstinence, or reduced intake may be necessary and in some cases medication (Jaffe & Ciraulo, 1985) and/or medical supervision is needed to take the person safely through withdrawal

stages.

Because of the tenuous balance in brain chemistry in a person with severe mental illness, the chemical effect of illicit drugs and alcohol places these patients at high risk for symptom activation and relapse. These illicit substances may reduce the effectiveness of the prescribed medications by resulting in a decreased neuroleptic effect (Salzman & Hoffman, 1983); or the patient may become non-compliant with medication to experience the effects of the illicit substances, or to ingest a greater quantity of the illicit substances without becoming rapidly intoxicated due to the additive effects when combined with medication (Cohen, 1977). The dangers in the interactions between the medications and illicit substances are noted to have very serious consequences (Bouricius, 1987; Salzman & Hoffman, 1983).

From my own observations, patients with more severe and active symptoms have more difficulty in gaining control over the use of substances than do those patients whose psychiatric symptoms are more frequently in periods of sustained remission, thereby their entire situation is worsened, and multiple symptoms are exacerbated. Treatment staff note that some severely mentally ill persons may indulge in the use of illicit substances when their psychiatric symptoms are returning, therefore, in some cases the mental illness may precipitate substance abuse versus the use of illicit substances precipitating symptoms of mental illness. In either case, the MICAA patient is a candidate for frequent hospitalizations. The provision of MICAA treatment can reduce the recidivism rates as patients begin to understand the interaction

effects and gain some control over the use of illicit substances (Sciacca, 1987a).

In my work educating and training mental health professionals, I have noted that they experience less frustration and burnout when they understand the seriousness of the dependency that patients have upon illicit substances. Staff can then develop realistic expectations and goals for each patient's course of recovery. Environmental factors that involve patients in substance abuse are carefully attended to. Staff are taught how to recognize these factors and patterns. They are also taught to help patients recognize and work on impinging environmental factors.

The use of a non-confrontational approach regarding denial in MICAA patients, not only serves as an engaging factor, it is also in keeping with the supportive approach used when working with severe mental illness. When denial is viewed as a defense to protect one's perception of their own well-being, it is important that as a defense it be worked through in a gradual manner. We do not confront the denial in a way that may be too intense for the fragile defense structures we often find in the severely mentally ill. Within this realm, mental health professionals can provide substance abuse treatment utilizing the supportive approach they employ when treating the patient's mental illness.

Working with Families, Friends and Advocates of MICAA Patients---MICAA-NON:

Just as with alcoholism and drug dependence, mental illness also effects the entire family system. When a family member has both severe mental illness and substance abuse this is often

confusing and devastating. The Alliance for Mentally Ill (AMI) consists of numerous families who are educated about the physiological aspects of mental illness, medications used, and the state of the research. This has freed many families from guilt, shame or blame for their relative's disabilities. Many families are not as well informed about substance abuse disorders (Sciacca, 1988). They often believe either that their relative can control this illness at will, or that their relative abuses substances because he/she is mentally ill. The latter belief condones treatment for mental illness that ignores the substance abuse problem. Some families are uncertain about the correct diagnosis of their relative and are confused over whether the person is mentally ill or a substance abuser. Because of the lack of availability of comprehensive services families do not know where to get help for their MICAA relative. In developing MICAA patient programs I have also initiated a family component called MICAA-NON. MICAA-NON groups are not limited to families with relatives in treatment, or to any catchment area. These groups provide staff leadership while fostering the development of self-help leadership among family members. Discussion, counseling, and education are provided. As in most support groups one valuable experience is that members learn they are not alone with these problems. We all work together to find solutions. Educational materials provide information that alleviate self-blame and doubt regarding substance abuse. The object of MICAA-NON is to improve and strengthen the well-being of family members as well as their MICAA relative.

What About Services That Are Not Provided by Mental Health Agencies?:

For example, drug and alcohol detoxification or rehabilitation programs. Here we find another gap in our treatment system. Many alcohol detoxification or rehabilitation units do not feel adequately staffed to admit patients on medication who have severe mental illness. More often, MICAA patients end up in psychiatric hospitals where medically supervised detoxification occurs only when the hospital is doing thorough screening for substance abuse. Psychiatric hospitals also become detoxification agencies for chemical abusers who have acute toxicity and/or acute substance induced organic mental disorders. Since the acute symptoms are likened to those in mental illness, patients with these symptoms are diverted to psychiatric hospitals rather than to drug or alcohol detoxification units. Problems arise when the hospitals are unable to discharge these patients due to lack of residential opportunities and substance abuse programs for aftercare that will or can take them. The CAMI patient may end up in an intermediate psychiatric care unit, when in fact they have compensated. There can be further complications when CAMI patients are mixed with severely mentally ill patients on the wards, since these patient groups usually function at markedly different levels.

Obtaining alcohol detoxification services for a MICAA patient with psychiatric symptoms in remission is easier than finding long term rehabilitation programs. In the few detoxification programs that do take MICAA patients these patients are in the minority, and often the approach and the intensity of the program may be

incompatible to what the MICAA patient can endure.

There is a need for these services for MICAA patients. Many of them cannot abstain or reach abstinence in the community, and many of them need medically supervised detoxification, but not psychiatric hospitalization. It appears that staffing patterns may have to change for these programs to provide comprehensive services for MICAA patients, or programs will have to be developed exclusively for the MICAA patient. In each of the MICAA programs I develop, a directory of adjunct alcohol and drug treatment services is compiled. MICAA staff conduct an on site visit and complete a standard questionnaire to ascertain the compatibility of the service to various MICAA patient profiles. The visit provides education for the staff and results in a directory of pre-screened adjunct services.

Continuity of Care for MICAA and CAMI

There are other multiple afflictions that cause similar dilemmas for professionals who try to obtain services (Rounsaville, Weissman & Kleber Study [Cited in Meyer, 1986]). For example, in my experience I have found that opiate addicted persons with alcoholism who are on methadone maintenance have limited choices for alcohol or other illicit drug detoxification. This patient category also has difficulty obtaining alcohol treatment. It has also been my experience that counseling takes place for all of the addictions, including alcohol, within the methadone maintenance setting. These patients also have mental health problems (Rounsaville, Weissman & Kleber Study [cited in Meyer, 1986]) in some cases to a lesser degree than the MICAA patient but not in all

cases. There is also severe mental illness among this patient population.

The model of MICAA treatment can be utilized here in the reverse. Substance abuse staff need education about mental illness; and to begin to screen for the symptoms to identify high risk patients. They can provide groups utilizing support and education to patients regarding mental health. These groups may serve to bridge the gap for adjunctive mental health treatment. The use of medications needs to be understood and sanctioned by the substance abuse professional (Daley, Moss, & Campbell, 1987), and the symptoms of various personality disorders must be recognized and empathized with.

In alcoholic patients it is clear that the same dilemma is evident. Patients with alcohol addictions are usually not seen as appropriate patients for mental health clinics. Alcoholic patients also suffer mental illness, usually less severe than the MICAA patient, but in some cases just as severe. Depression is a symptom which requires careful diagnosis in the alcoholic person. Where there are major depressive symptoms medication may be required (Wallace, 1985). In alcohol treatment, mental health status screenings are frequently done. But differential diagnosis may require testing beyond such screenings (Wallace, 1985). Cross-addiction between alcohol and cocaine has been found to be very common. Alcohol subdues the effects of cocaine when the abuser is feeling over stimulated. It has been noted that alcohol is also used for the depression experienced when coming off the cocaine but that it worsens the depression rather than relieves it (Levin,

1987). Another danger in this cross-addiction is that the person intoxicated by cocaine can consume excessive amounts of alcohol without experiencing alcohol intoxication until the cocaine wears off. At such time the person may be in a situation, such as driving a car, and be overcome by alcohol intoxication, causing imminent danger to themselves and others.

Suicidal patients from MICAA and CAMI patient groups are traditionally admitted for psychiatric care, therefore, there has been identified one area of collaborative treatment that all agencies agree upon.

There needs to be clearer distinctions among the MICAA and CAMI patients within the numerous sub-groups they represent. More education regarding differential diagnosis needs to be provided for all of the service agencies. Continuity of care for patients in all categories will necessitate clarity about where and when comprehensive treatment can be provided within an agency, and/or when collaborative treatment is indicated for multiple disorders. It is important to determine which primary approach is most effective for the patient; thereby designating one of the agencies as the primary provider. Where collaborative treatment occurs each provider must be accounting for the multiple disorders within their treatment process. Collaborative treatment planning and communication is most effective and necessary.

Finally, there are MICAA and CAMI patients who do not receive treatment from anyone. These include: those among the homeless, those who have been lost to our existing models of care, and those who have never engaged in our services. New treatment models may

be necessary to engage these persons in treatment. Models must address the needs of these people, which include the degree or frequency that they are able to engage in services. We cannot deem people untreatable because they do not meet our traditional criteria for treatment readiness and modes of participation. It is our responsibility to learn to engage and treat the vast array of MICAA and CAMI patients who remain outside of our present system of care.

In addition, we have to address the legislative criteria and guidelines developed for the treatment of alcoholism, drug dependence, and mental illness which sometimes separate the funding and admission criteria for these services. These criteria often prevent agencies from collaborating.

In New York State the Office of Mental Health (OMH) has been designated the lead agency for providing services for MICAA patients. Numerous models are used, including collaboration. Many programs have been developed within the state psychiatric care facilities. Among these programs are five facilities that are designated as training sites. The programs at these sites serve to educate others in their region of the state. The OMH Bureau of Staff Development has developed a training program, a manual, and a film on this topic area. My own work as Coordinator of MICAA Training Site Programs, and the work I do in Statewide Program and Staff Development includes assessing the availability of continuity of care services within a given community. This includes services necessary for MICAA and CAMI patients, and the programs and educational opportunities that must be developed to provide comprehensive continuity of care.

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